

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Presbyterian Hospital of Plano P. O. Box 910812 Dallas, TX 75391	MDR Tracking No.: M4-04-3840-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address AMERICAN CASUALTY CO OF READING PA BURNS ANDERSON JURY & BRENNER PO BOX 26300 AUSTIN TX 78755-0300 Austin Commission Representative Box 47	Date of Injury:
	Employer's Name: Texas Health Resources
	Insurance Carrier's No.: 900000008

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/18/02	11/21/02	Surgical Admission	\$34,865.51	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

This bill qualified as a Stop Loss bill per rule 134.401. If audited charges exceed \$40,000.00, carrier should reimburse 75% of total charges (134.401 C (6)). Per Stop Loss rule, this method is to be used in place of and not in addition to per diem/Fair and Reasonable or any other method of audit. In addition, the only items allowable by TWCC for the carrier to deduct are patient convenience items and non-compensable area treatment. It should also be noted that implant invoices are not required by TWCC to be included in submission of a complete medical bill. Invoices are required when their individual reimbursement should be considered. In a stop loss bill this is not a consideration and invoices are therefore not required.

PART IV: RESPONDENT'S POSITION SUMMARY

No position summary received.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed \$40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to \$3,354 (3 times \$1,118). The requestor billed \$1,650.00. In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows

Documentation was not provided for implantables.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services. The amount paid was \$3,405.18

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Gail A. Anderson	03/10/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____